

Muscogee (Creek) Nation
Division Of Children & Family Services
Foster/Adoptive Home Assessment
Medical Examination Report

Name: _____ Birth Date: _____ Height: _____ Weight: _____
 Address: _____ County: _____

General Physical Examination - Report of Findings: (To be completed by physician)

Blood Pressure _____ Pulse Rate _____ Temperature _____

	Normal	Abnormal
Eyes		
Ears		
Heart		
Lungs		
Abdomen		
Nervous System		
VDRL		
Urine		

If abnormal please specify and attach report: _____

Medical History:

List any communicable, hereditary or debilitating diseases, especially psychoneurotic disorders, epilepsy, fainting spells or operations. Is the patient on any medications? _____

Over what period of time have you known the patient professionally? _____

Does patient have any condition that would impair ability to care for children? _____

Comment of Physician: (Regarding patient's emotional, intellectual and physical health) _____

Physician's Signature: _____ Date: _____
 Address: _____ Telephone No.: _____